UTAH DIGITAL HEALTH SERVICE COMMISSION MEETING

Thursday September 3, 2020, 10:00 AM – 12:00 PM MDT

Utah Department of Health Online Google Meet
meet.google.com/ofe-ksse-etm
Phone Number: 478-419-3290
PIN: 322 070 961#

Minutes

Members Present: Rand Rupper (Chair), Anika Gardenhire, Dallas Moore, Matt Hoffman, Matt McCullough, Sarah Woolsey, Todd Bailey, Trish Henrie-Barrus, Ben Hiatt, Henry Gardner

Members Absent: Mark Dalley, Ken Schaecher, Preston Marx

Staff Members: Navina Forsythe (DOH), Kailah Davis, Valli Chidambaram (DOH), Humaira Lewon (DOH), Huaizhong Pan (DOH), Robert Wilson (DOH)

Guests: Marc Babitz, Sid Thornton (Intermountain Healthcare), Mark Hiatt, Wu Xu, George McEwan, Micah Vorwaller, Sheila Walsh McDonald, Valli Chidambaram, Carolyn Tometich, Nan Klein, Kirt Cundick, Ronald Larsen, Matt Hansen, Benjamin Weller

1. Welcome and Introduction:

Randall Rupper started the meeting at 10:02 am and welcomed everyone, everyone attending the meeting gave a brief introduction

Navina gave a couple of updates on executive leadership at the Department of Health. Currently appointed interim Executive Director is Rich Saunders, Deputy Director is now Dr. Miner and Heather Borski is the other Deputy Director.

2. Approval of Minutes:

The July 2020 meeting minutes were reviewed.

MOTION 1:
Henry Gardner said he was shown as absent in the last meeting but he attended via the phone; the minutes will be updated to reflect this change. Henry Gardner made the motion for approval, Patricia Henrie-Barrus seconded, and all voted in favor.

Action Item #1: Humaira will update the July 2020 minutes to reflect the suggested change.

3. Discussion Items

a. DHSC Telehealth Subcommittee Update

- The telehealth subcommittee consists of Matt McCullough, Preston Marx, Kenneth Schaecher, and Patricia Barrus and they met last week to kick things off.
- During the initial meeting, the purpose and goals were discussed. The current purpose statement is to "discuss and develop policy recommendations to share with the commission that will reduce barriers and promote the adoption of telehealth in the state of Utah."
- Some of the goals identified revolves around identifying barriers around payments. House Bill 313 that was passed in the last legislative session and the language in that bill surrounding third-party payers paying a commercially reasonable rate and what we might do to look at what that means was discussed. The current state of telehealth policy in Utah and federal waivers that have been put in place and what that might mean for the future on a federal level was a discussion of the subcommittee as well. The subcommittee also thought it would be good to have a focus on mental health and how telehealth can have an impact in that space.
- The subcommittee plans to meet every 2-3 weeks initially to identify actionable items. Henry Gardener noted that he would like to join the subcommittee.

  Matt mentioned that he was approached by Mark Andrews with the Health and Human Services Interim Committee about doing a presentation.

b. DHSC HIT Strategic Plan Update

- Navina Forsythe mentioned that Humaira provided a document/template for lead agencies to report the status of projects in the HIT strategic plan. Navina further noted that earlier this year the DHSC discussed different approaches to monitor the progress of projects and those suggestions, such as color codes for project status, are reflected in the distributed document. After receiving the statuses, Navina will work on aggregating all information and feedback, these statuses will be discussed during the November meeting.
- Sarah Woolsey mentioned that she believes the Office of the National Coordinator (ONC) has updated their HIT plan and it may be worth reviewing it [ONC's HIT plan] to ensure DHSC HIT plan aligns with ONC's, Navina agreed. linking us to that. Navina noted that she has it and that is a great suggestion.
- The topic of funding the HIT projects was highlighted and Navina mentioned UDOH and UHIN attended a presentation on the transition from HITECH to MES/MMIS to sustain HITECH initiatives. Navina went on to note that the presentation was informative on how to access some of that funding and what it can be used for. The presenter agreed to come present at DHSC's November meeting and Navina will try to get Medicaid folks to attend as well.

Action Item #2: Navina will aggregate the information/feedback from the project statuses to discuss during the November meeting.

Action Item #3: Navina will coordinate the Medicaid group attending the November meeting.

c. Social Determinants of Health (SDOH) Update

- Sarah Woolsey provided an update on the social determinant of health efforts, these include:
    1. The addition of a goal around social determinants of health and interoperability in the state HIT plan.
    2. Leveraging current SDOH groups to advance SDOH interoperability efforts. Sarah went on to note that Leavitt Partners are being hired by Intermountain Healthcare and the 211 to support advancing interoperability around the Unite Us Platform which connects healthcare organization providers to community-based organizations. The Leavitt Partners are funding the Unite Us Platform as well as advancing how interoperability is seen within some systems.
    3. Sarah mentioned that Navina and herself will be participating in a multi-stakeholder meeting, hosted by Leavitt Partners, to discuss interoperability and social determinants. Sarah and Navina will provide an update at the next meeting.
    4. Sarah noted that there are plans to create and provide a white paper on DHSC SDOH projects and community involvement to the new executive director of the Department of Health. Sarah further highlighted that the paper should address barriers, interoperability, and patient engagement.

Action Item #4: Sarah and Navina to provide an update during the November meeting on the meeting they attended that was hosted by the Leavitt Partners.

d. 42 C.F.R. Update

- Overview. Micah Vorwaller, UDOH's Assistant Attorney General, presented the changes to 42 C.F.R (see slides). Micah mentioned that there were updates to the Substance Use Disorder rules Part 2 which went into effect on August 14th, 2020. He further noted the CARES Act of 2020, which was approved by Congress and signed into law, also made several changes to 42 C.F.R. and highlighted the changes will better align Part 2 with HIPAA.
- Summary of Changes. Micah noted that a lot of the changes that were made to 42 C.F.R. were to address the opioid crisis, allow for the sharing of information for better treatment and care while maintaining privacy, and aligning with HIPAA (the privacy rules and restrictions on Part 2 data are more restrictive than HIPAA). Micah highlighted the different changes; see slides 3-5. He noted the following changes:
    1. Record Definition. Micah noted that the definition of "records" was updated for there to be an exception for information that can be conveyed orally by a Part 2 program to a non-Part 2 provider. This allows Part 2 providers the ability to write information without it becoming a record subject to Part 2. Micah noted that this change intends to better facilitate care coordination between Part 2 providers and non-Part 2 providers.
    2. Applicability. Micah noted the definition change in 1 also impacted applicability, which is § 2.12. He noted that this change provides that the recording of information about an SUD and its treatment by a non-Part 2 provider does not

render a medical record subject to Part 2, provided that the non-Part 2 provider segments or holds a part any Part 2 patient record previously received.

3. Consent. Micah discussed consent requirements and noted that there will be "big" changes around consent in the next year due to the passing of the CARES Act. He noted that consent permits patients to consent to the disclosure of their information for operations purposes to certain entities without naming a specific individual and includes special instructions for health information exchanges (HIEs) and research institutions.
4. Micah continued to review some information on his slides discussing prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments, disclosures to prescription drug monitoring programs, and medical emergencies. Micah also discussed some changes to disclosures for research under Part 2 such as permitting research disclosures of part 2 data by a HIPAA covered entity or business associate to individuals and organizations who are not HIPAA covered entities or subject to the Common Rule. For more information regarding these changes, see slide 4.

- Micah explained that the 42 C.F.R. Part 2 will be heavily impacted by the CARES Act modifications.

e. Behavioral Health Services – Telehealth and Technology

- Nan Klein, cofounder of the Utah Institute for Psychotherapy, presented on the impact of COVID-19 on behavioral health in the U.S focusing on 1) the results of a 2020 survey, 2) telepsychology and teletherapy, 3) effective and ethical practice, and 4) anticipated future issues given the very rapid and successful transition to telepsychology.
- <u>Mental Health, Substance Use, & Suicidal Ideation During the COVID19 Pandemic.</u> Nan presented the results from a 2020 survey. She noted that the CDC in conjunction with Harvard Medical School in Melbourne Australia along with Qualtrics in Utah published the results of a survey that was conducted in June of 2020 from 5,412 randomly selected adults in the U.S. Their data was compared to the same period in 2019. Reports from the 2020 survey indicated that 26% of this subject pool reported symptoms of an anxiety disorder and 24% of a depressive disorder. In 2019 only 8% of folks endorsed symptoms for an anxiety disorder and only 7% for a depressive disorder. Significant increases in people self-reporting symptoms of anxiety and depression. 13% started or increased substance abuse for coping, 11% seriously considered suicide in the past 30 days, 41% of Americans had some sort of behavioral health symptom. Black people are nearly 2x as likely to use or abuse substances or consider suicide. Hispanics are most affected by the pandemic with the highest rate of symptoms, substance abuse, and suicidal thoughts. Young people are 8x more likely to report symptoms.
- <u>Telepsychology and teletherapy</u>.
    - <u>History</u>. Nan noted that telepsychology is not new but represents a pandemic pivot for a form of practice. Nan found a 1959 University of Nebraska pilot telemedicine project with mid-century video technology that ended up being too expensive and impractical. Nan noted that the 1990s saw an increase with established Internet and 2-way video platforms. As a result, the DOD and VA developed sustainable larger-scale telepsychology services. Nan defined

telepsychology noting that it is "the provision of psychological services using telecommunication technologies." Nan further noted that interactive video conferencing in real-time is synchronous telepsychology and emails, faxes, and discussion forums are asynchronous.
    - During the pandemic, the transition to telepsychology was swift, immediate, and was generally the sole option. Nan highlighted that an American Psychiatric Association shows that 63.6% of psychiatrists did not use any form of telepsychology before the pandemic. After the pandemic, only about 2% did not use some form of telepsychology. She further went on to highlight that there is a dramatic increase in access to care and that is one of the things that is contributing to the awareness of the utility and delivery of telepsychology services.
    - Nan noted some of the advantages to telepsychology such as avoiding unnecessary health risks, time savings and less stress, environmental benefits, and cost savings (less fuel and greenhouse gas production). She noted that there is more flexibility with appointments, more privacy, and anonymity, more flexibility in choosing clinician, easier to involve family members and significant others in treatments, more naturalistic exposure therapy with people with phobias on the anxiety spectrum, eliminated transportation issues.
    - Incorporating telepsychology in a practice requires adherence to best practices. Telepsychology shows higher retention rates, however, there are slightly longer-lasting effects with in-person treatments but there are more dropouts with in-person treatments.
    - Nan highlighted challenges with telepsychology. These include having to master the technology, how to troubleshoot quality and connectivity, how to adjust your workflow and ergonomic setup, and navigate the psychotherapeutic process with different cues.
- Ethics. Nan noted that there a need for supplemental training regarding compliance with legal and ethical obligations. Nan discussed how the Association of Psychology Boards created the Psychology Interjurisdictional Compact (PSYPACT) and 13 states have enacted PSYPACT and Utah was the second state, after Arizona, to enact PSYPACT in 2017. PSYCPACT will take effect in 2 additional states in 2021 and 12 states and DC currently have pending legislation.
- Future Issues. Nan mentioned that post-pandemic the concerns for use of remote treatment are focusing on the effect of the states of emergency expiring and what kind of impact that will have. Will there be a reversion to pre-pandemic policies? Withdrawal of reimbursement for telepsychology? Etc.

f. Issues & Observations Utilizing Telemental-Health Technology in Rural Utah During the Covid-19 Pandemic

- Kirt Cundick, the ICH Sevier Valley Clinic in Richfield Utah, discussed mental health services in rural Utah based mostly on his own experiences and observations. He works in a very underserved area.
- Kirt mentioned that access to mental health and substance abuse services is sharply limited due to difficulty in recruiting and retaining licensed mental health providers. He further noted that 61% of all rural counties have no psychologists, 80% have no

psychiatrists. He noted that limited access to mental health and substance abuse services is a "bigger problem" in Utah because county size and geography are not addressed; some of the more isolated counties have much greater access problems. There are very high suicide rates, at-risk demographics including a high indigenous American population. The primary employer industries in Sevier county are also associated with higher suicide rates. This includes oil/gas, coal mining, hard rock mining, and associated industries like trucking and diesel repair. Kirt noted that access to lethal means has been a big issue; the firearm ownership rate is very high.

- Kirt mentioned that substance abuse and trauma are very prevalent in Sevier County. There are access barriers with geography and infrastructure and it is an issue that there is no public transportation in Sevier County. There is no direct bus access to the Wasatch front. The acceptability of mental health services is a big issue, confidentiality in the waiting area is an issue. IHC has thankfully been providing some telepsychiatric services through Dr. David Burrow. He has been proving these services on a short-term basis with physicians here through stabilization, once someone is stable, he transfers care back to the primary care physicians. Kirt reached out to the Central Utah Counseling Services, the local community mental health center, and the center had also been providing limited psychiatric services via distance technology. One of the things Kirt is involved in is being a site supervisor for the Utah Psychology Internship Consortium which has been providing group supervision and distance meetings in support of the training program.
- Kirt discussed the utilization of telemental-health services to counter COVID-19 related restrictions. Central Utah counseling services shifted exclusively to telemental health services for all outpatient services. Kirt reviewed some benefits and concerns about telemental-health delivery. Telemental-health has been very helpful in terms of addressing geographic and transportation barriers restricting access to care. There are significant geographic swaths in which suitable broadband is unavailable and also a lack of cell service, which then makes telemental-health not feasible. Telemental health has the potential to improve the generalizability of learning and attendant benefits by providing intervention in the home environment rather than in the more artificial office environment. Kirt further noted that telemental health availability has facilitated services to medically compromised patients who are homebound, which is very helpful. However, there are still significant limitations regarding specialty care. He went on to note that telemental health does address privacy concerns inherent in rural treatment settings. The option to access distant providers can circumvent the dual-role conflicts inherent in rural mental health practice.
- Kirt discussed some of the observations that Dr. David Burrows sent to him regarding the following and Kirt noted below what was highlighted:
    - Access to mental health services and the need to increase the internet infrastructure for information exchange to make it possible for some people.
    - Safety issues and some patients have to be seen in a clinic.
    - Prescribing difficulties to prescribe controlled substances from a distance.
- Kirt shared some of the concerns he has about the continuing implementation of telepsychology. One is revenue competition between local mental health providers and geographically distant providers that may inhibit improvements to local mental health infrastructure and provider access. He noted that there is concern about shifting focus

from locally provided services to telepsychology, such concern may serve to undermine priority recruitment and retention of local mental health providers.

g. Behavioral Health Integration – Successes and Lessons Learned

- Getting the data. Carolyn Tometich is the Executive Clinical Director for the Behavioral Health Clinical Program. The program has behavioral health throughout Intermountain, from inpatient unit for both adults and children to what Kirt is doing in primary care clinics integrated with primary care providers, there is a spectrum of services. Carolyn highlighted a couple of uses of how data is used within Intermountain and what the goals are for the future. The program was able to receive some suicide data in 2013 and was able to contact the State Department of Health and request death data that included the date of death and cause and manner. A file was received with all death records and was matched to Intermountain's patient records.
- Findings. Carolyn discussed the suicide rates from 2000-2012 for Intermountain patients. Carolyn went on to review some of the lessons learned and from the analysis and highlighted several Intermountain trends. She noted that about 40% of those patients who died by suicide had been seen in the Intermountain system within 4 weeks of their death. In addition, 25% of patients had touched the system within 7 days. Carolyn noted that the statistics were "stunning" and led to Intermountain working closely with the State Division of Substance Abuse and Mental Health to collaboratively develop a suicide prevention care process model. This resulted in the implementation of a standardized depression screening and a suicide risk assessment.
- Next steps. Currently, Carolyn is in the process of working with Navina and the Department of Health to receive death data from 2014-2018 with an IRB request. The current hypothesis is "more mental health care in primary care will reduce the overall suicide rate." Carolyn noted the long-term goal is having real-time death data with cause and manner of death data so that Intermountain can be engaged in real-time quality improvement. Carolyn further noted that she is working to get more data related to social determinants of health.

h. Controlled Substance Database Sharing with Behavioral Health

- Ron Larsen discussed the Controlled Substance Database (CSD) and its relationship to mental health under statute 58-37 F subsection 30120. Ron noted that there is a lack of participation from providers accessing the database in the therapeutic settings for treatment. Ron went on to mention that the statute gives authorization to a mental health provider in concert with a treatment program and physician's assistant or pharmacist who is involved in that program and will work with that patient and provide direction for information regards to the controlled substance database findings.
- Ron noted that there is information within the CSD that would be helpful to mental health providers. For example, the CSD has external records within the database and those records consist of court information, hospital overdose events, and the patient dashboard provides information that may indicate a patient's risk of a drug overdose such as multiple provider epidoses which is important to know. Ron further noted that the CSD also provides users a history of where the patient has been du a 5-year period. Ron encouraged the use of the Controlled Substance Database and provided contact

information for him and his staff for anyone who needs assistance with understanding and using the CSD.

Wrap Up and Next Steps:

Rand thanked everyone, said it was a great and informative session. This can continue through the subcommittee as discussed earlier and can reach out to Matt McCullough as the contact point. He thanked the attendees and presenters.